Codify
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Dermatology Coding Alert

Melanoma: Including Repair in All Melanoma Codes? Read This First

Are these coding myths causing you to leave up to $300 on the table?

Melanoma accounts for less than 2 percent of skin cancer cases in the U.S. □ but it causes most of the deaths, according to cancer.org. Some groups estimate that melanoma causes as much as 77 percent of the deaths from skin cancer.

The good news is that most people with melanoma are cured by their initial surgery, says cancer.org, citing the 95 percent five-year survival rate. That's where your practice comes in. But while your dermatologist is busy helping patients, make sure your coding is helping your practice get its full deserved reimbursement □ by making sure these myths aren't blotching your claims.

Myth: Melanoma-related CPT® codes always include repair.

Reality: Not always. When the surgeon excises a lesion, the code includes simple (single-layer) closure. But if the surgeon performs a layered closure, you can separately bill the intermediate closure.

Do this: What you need to know to bill the closure is the longest dimension of the wound. This is likely to be quite a bit longer than the excision itself, because surgeons often create an elliptical excision, which is needed for a clean closure. You will identify the total length of the repair and choose the intermediate repair code that matches that length.

For instance: The surgeon creates an elliptical excision 6 cm long surrounding a 2.5 x 1.5 x 1.0 cm lesion excision with 1 cm margins on the scalp. You should report the intermediate repair with CPT® code 12032 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 2.6 cm to 7.5 cm) in addition to the excision code (11604, Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 3.1 to 4.0 cm).

On average nationally, CPT® code 11604 alone brings $319.45 in a non-facility, according to the Medicare Physician Fee Schedule. Reporting 12032 separately brings in an additional $306.87.

These rules for closure coding apply for excision of benign and malignant lesions of both the integumentary system (114xx-116xx) and the musculoskeletal system for lesions such as lipomas (e.g., 21011, Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm). The only difference is that you can only separately report complex repair with muscle/soft tissue lesions, while you can separately report intermediate and complex repair with integumentary lesions.

Myth: You can code melanoma excisions as soft-tissue excisions.

Reality: Not always. Although they may become invasive, melanomas are skin tumors, and you should code their excision as such. The dermatologist must go below the fascia before you can consider the soft tissue codes.

Example: The surgeon re-excised a melanoma of the upper arm, removing a 2.9 cm lesion with 0.1 cm margins. The op note documents that the surgeon removed subcutaneous tissue down to, but not including, the fascia, and performed an intermediate repair.

You would not report CPT® code 24071 (Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or

greater) for this service. Code the service as 11604 (Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm).

Myth: You can always code for surgical prep of a graft after a melanoma removal.

Reality: Not always. Be careful not to automatically report surgical preparation when your dermatologist performs a skin substitute graft.

Scenario: The dermatologist excises a 3-cm melanoma with a 2.5-cm margin from a patient's left arm, then applies a 40-sq.-cm skin substitute graft with sutures and dresses the area.

In this example, the dermatologist applies the skin substitute graft immediately following a surgical excision, so you should not additionally report a surgical preparation code (15002-+15005, Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar [including subcutaneous tissues], or incisional release of scar contracture ...)

Instead, according to CPT® instruction, "When a primary procedure requires a skin substitute ...for definitive skin closure (e.g., ... deep tumor removal)," you should report the appropriate graft code in the range 15100-+15278 in addition to the primary procedure 11606 (Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm) in this case and skip the surgical preparation codes.

Learn limitations: You should only report a surgical preparation code with the skin-substitute graft when the dermatologist fulfills at least one of these conditions, according to CPT® instruction:

- "Appreciable nonviable tissue is removed to treat a burn, traumatic wound or a necrotizing infection"
- Or, "the clean wound bed may also be created by incisional release of a scar contracture resulting in a surface defect from separation of tissues"
- "The intent is to heal the wound by primary intention" such as autograft or skin substitute graft.

Myth: You would report the same diagnosis code whether a melanoma is in situ or malignant.

Reality: That's true for now but not for long.

The ICD-9 diagnosis codes for malignant melanoma of skin (172.x) do include "melanoma in situ" But effective Oct. 1, 2015, the code set for malignant melanoma of skin will expand considerably. In addition to more specificity in body location (for example, different ICD-10 codes for melanoma on right and left eyelids), the new diagnosis codes will distinguish between malignant melanoma and melanoma in situ.

Example: The ICD-9 code for melanoma of the skin of the eyelid is 172.1 (Malignant melanoma of skin of eyelid including canthus). Until Oct. 1, you would report this code for any eyelid, including melanoma insitu.

However, in ICD-10, you will have these expanded options:

- C43.10 Malignant melanoma of unspecified eyelid, including canthus
- C43.11 ...right eyelid, including canthus
- C43.12 ... left eyelid, including canthus
- D03.10 Melanoma in situ of unspecified eyelid, including canthus
- D03.11 ... right eyelid, including canthus
- D03.12 ... left eyelid, including canthus.

Tip: Just as in ICD-9, your first stop when coding for a neoplasm in ICD-10 is the Neoplasm Table. You'll find the table just after the end of the Alphabetic Index in your coding manual, rather than under "N" in the Alphabetic Index, says **Joan Usher, BS, RHIA, COS-C, ACE**, AHIMA-Approved ICD-10-CM Trainer with JLU Health Record Systems in Pembroke, Mass.

Go deeper: For more on this ICD-10 transition, see "ICD-10: Specify Malignant Melanoma or Melanoma In Situ" in Vol. 10 No. 9 of Dermatology Coding Alert.